

**CHRISTOPHER WAYNE LESTER
MADISON MEDICAL GROUP
RECORDS
14-Q**

cnrq/01-01-96/*6

** VENDOR COPY **

1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner



October 1, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21

HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [REDACTED]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - REQUEST FOR INFORMATION

CAMC GENERAL DIVISION PAIN CLINIC, please send me the following
information regarding this claim:

AUTHORIZATION WAS GRANTED ON SEPTEMBER 12, 1996 FOR AN EVALUATION BY CAMC PAIN
CLINIC. PLEASE PROVIDE AN UPDATE ON THE CLAIMANT'S CONDITION AND THE TREATMENT PLAN.
FORWARD TO MY ATTENTION AT: P.O. BOX 431, CHARLESTON, WV 25322 OR FAX#(304)926-5423.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SNYDER J MARK
CAMC - REHAB UNIT

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

A large, stylized handwritten signature, possibly reading "TB", is written over the signature block.

TB.

500688.015.0571

**Charleston Area Medical Center Pain Management Program
Initial Examination and Clinical Evaluation**

NAME: Christopher Lester
DATE: 9/16/96
PAIN CLINIC PHYSICIAN: Timothy W. Nelson, M.D.
REFERRING PHYSICIAN: Madison Medical Group, Madison, WV

CHIEF COMPLAINT:

Chronic low back pain.

HISTORY OF THE PRESENT ILLNESS: The patient was injured in August of 1994, when he was carrying a header in the rain, while he was putting together a mobile home. He slipped on the wet ground and went into a large ditch that was being dug for a swimming pool. He said that the header came down on his shoulder and since that time, he has suffered with low back pain, some pain in his tailbone, and for some time period, he had some pain in his neck; his primary problem now is low back pain at or just below the level of his belt line with occasional sharp, shooting pains into his left hip and down his left leg. He has no complaints of bowel or bladder dysfunction. Other than the occasional sharp shooting pains in his left leg, he has no numbness, tingling or weakness in his extremities. He has been through the work hardening program, which he was basically unable to participate in because of the level of his pain. He was instructed on some exercises, which he tries to do at home on a daily basis. He is not taking any narcotic analgesics at the present time, but he has been treated with Darvocet in the past, which he said was pretty good at relieving his pain. He had an MRI of his lumbar spine which revealed no disc herniation. The neural foramina were patent. There was no compression fracture identified and the vertebral body heights and alignment appeared to be normal. In August of 1996, he also had a coccyx film, AP and lateral coccyx film, which demonstrated no acute fractures or other osseous abnormalities.

PAST MEDICAL HISTORY is contained in the outpatient history and physical form.

PHYSICAL EXAMINATION: Reveals a 24-year-old white male appearing to be his stated age of 24. He is 5'7-1/2" tall and weighs 265 pounds. His blood pressure is 135/72, and his pulse is 84. Deep tendon reflexes are 1+ and symmetrical throughout. Straight leg raising is accomplished bilaterally to 90 degrees, however at 90 degrees on the right, he experiences sharp pain in his left hip and in his left leg. Motor and sensory examination are within normal limits. The lumbosacral paraspinal musculature is nonspastic but reveals several areas of point tenderness.

PAGE TWO

IMPRESSION: Chronic lumbar strain with a questionable left lumbosacral radiculitis.

PLAN:

1. Continue Elavil.
2. I cautioned him about the extended use of Toradol as this medication can have hepatotoxic effects and is essentially not recommended for longer periods than a week at a time. He has been on this medication now for over a month, and while his physicians at the Medicine Clinic are well aware of this, and they have discussed this with him, I think that switching to another nonsteroidal anti-inflammatory drug may be in the patient's best interest.
3. Neurontin 300 mg po t.i.d.
4. Workers' Compensation authorization for trigger point injections and lumbar epidural steroid injections (a series of three of each of these).
5. The patient should continue doing his home stretching and strengthening exercises as tolerated.

Timothy W. Nelson, M.D.
Vice Chief of Anesthesia, and
Consultant in Pain Management
Charleston Area Medical Center

TWN:nbc

signed but not read

PLEASE NOTE: AUTHORIZATION IS SOUGHT FROM WORKERS' COMPENSATION FOR THE ABOVE OUTLINED TREATMENT PLAN TO INCLUDE A SERIES OF THREE TRIGGER POINT INJECTIONS AND THREE LUMBAR EPIDURAL STEROID INJECTIONS, AS WELL AS PHARMACOTHERAPY WITH NEURONTIN, A NONSTEROIDAL ANTI-INFLAMMATORY DRUG AND PHYSICAL THERAPY. Please see attachments for further demographic information.

500688.015.0573

MADISON MEDICAL GROUP
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

TO: Greg Hughes-WC 926-5423

FROM: Robert B Atkins MD

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 9/30/96

ADDITIONAL COMMENTS: _____

CONFIDENTIALITY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US, THANKYOU.

*faxed
2:45 PM*

CarePoint

Care Point Physicians, Inc.

Madison Medical Group
Robert Atkins, M.D.
Ron D. Stollings, M.D.
John Mark Snyder, D.O.
705 Madison Ave.
Madison, West Virginia 25130
(304) 369-5170

September 30, 1996

Workers' Compensation Division
4700 MacCorkle Avenue SE
Charleston, West Virginia 25304-1964

Re: CI# 950006803
SSN [REDACTED]-3340
DOI 08/10/1994

To Whom It May Concern:

This letter is regarding Christopher Lester. Mr. Lester remains off work due to his comp related injury. His diagnosis codes are 847.2, 847.1, 845.

We are now waiting for an authorization to the pain clinic for treatment. His next appointment is October 16, 1996, however his return to work date is still undetermined.

Please feel free to contact me at any time.

Sincerely,



Robert B. Atkins, MD
in the absence of
J Mark Snyder, DO

plh

500688.015.0575

auth/01-01-96/*8 * VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner



September 12, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21
HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from SNYDER J MARK dated 09/11/1996, is Approved.

PER THE REQUEST FROM DR. J. M. SNYDER, DATED SEPTEMBER 10, 1996, THIS LETTER WILL SERVE AS AUTHORIZATION TO REFER THE CLAIMANT TO CAMC GENERAL DIVISION PAIN CLINIC FOR AN EVALUATION. A DETAILED MEDICAL REPORT SHOULD BE PROVIDED BY THE PAIN CLINIC OUTLINING THE TREATMENT PLAN. THIS PLAN AND ANY REQUESTS FOR AUTHORIZATION SHOULD BE DIRECTED TO MY ATTENTION AT FAX# (304) 926-5423.

Your authorization number is 196255141.
Authorized Dates are 09/11/1996 through 11/11/1996.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Director, Legal Services Division
P. O. Box 3922
Charleston, WV 25339-3922

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SNYDER J MARK
CAMC - REHAB UNIT

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

A handwritten signature, possibly "RJ", with the date "9/13" written below it.

500688.015.0576

MADISON MEDICAL GROUP
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAX COVER SHEET

FAXED

TO: Marcia Van Hook

FROM: Paula

RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 9-10-96

ADDITIONAL COMMENTS: _____

CONFIDENTIALITY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US, THANKYOU.

BOONE MEMORIAL HL /TAL. Madison, W. Va. X-RAY REPORT

E.R. Hou. OPD

FAXED

LESTER, CHRISTOPHER WAYNE 08-26-96

PO BOX 21 24 [REDACTED] 71 M W M

HEWITT, WV 25108 369-2432

FILM #

11417

EMPLOYER: TRI STATE HOMES COMPENSATION NUMBER 233153340

SS# [REDACTED] 3340

PAIN COCCYX DR. J. SNIDER OPD WR

PROCEDURE:

X RAY COCCYX 08-26-96

REPORT:

COCCYX:

AP and lateral coccyx films demonstrate no acute fractures or other osseous abnormalities.

ROBERT SMITH, M.D./nd
8-27-96

BR
5/6

Robert Smith, M.D.

M.D.

FORM # 56

500688.015.0578

surb/01-01-96/*6 ** VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner



July 24, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21

HEWETT, WV 25108-0000

Re: Claim. 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - REHAB BENEFITS SUSPENDED

Your TEMPORARY TOTAL DISABILITY benefits, paid during your participation in a rehabilitation program, have been suspended because:

Your claim may be closed in 30 days unless sufficient information is received to continue these benefits. After this 30-day notice period, you will be notified of final decision.

TO CONSIDER REINSTATING TTD BENEFITS ON A MEDICAL BASIS, A DETAILED MEDICAL REPORT NEEDED FROM THE TREATING PHYSICIAN ADVISING OF THE FUTURE TREATMENT PLAN, INCLUDING THE SPECIALIST THE CLAIMANT IS BEING REFERRED AND THE DATE OF THE CONSULTATION EXA

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SNYDER J MARK

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

500688.015.0579



PROFESSIONAL CONSENT

RE: Christopher W. Lester
SSN: 233-15-3340
DOB: [REDACTED]/71
DOI: 8/10/94
CLAIM NO. 950006803

I authorize CRA Managed Care, Inc. to be permitted to:

1. Review and obtain copies of all medical, psychiatric, hospital, vocational, and other records pertaining to this occupational injury or any prior related injury or disease.
2. Discuss my case and obtain reports from physicians and allied health professionals providing treatment or evaluation due to this occupational injury or any prior related injury or disease.

I authorize physicians and allied health professionals to discuss my case with and provide written reports and records to CRA Managed Care, Inc. related to this occupational injury or any prior related injury or disease. This may include detailed information as to my condition, treatment plan, prognosis, and anticipated dates for maximum medical improvement and return to work.

I further give permission to CRA Managed Care, Inc. to share the information so received with my treating physicians, independent medical evaluators and West Virginia Workers Compensation.

A photocopy of this form may be accepted as the original.

This authorization is valid for 90 days from the date of signature.

Signature Chris Lester

Date 7/5/96

Witnessed Marcia LaHock

MADISON MEDICAL GROUP
705 MADISON AVE.
MADISON, WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

FAXED

FAX COVER SHEET

TO: Greg Hughes
FROM: JM Snyder MD
RE: Christopher Lester

NUMBER OF PAGES INCLUDING COVER SHEET: 2

DATE: 9-10-96

ADDITIONAL COMMENTS: _____

CONFIDENTIALITY NOTICE: THE DOCUMENTS ACCOMPANYING THIS FACSMILE TRANSMISSION CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS TELECOPIED INFORMATION IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FACSMILE IN ERROR PLEASE NOTIFY US BY TELEPHONE TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENTS TO US, THANKYOU.

CarePoint

FAXED

CarePoint Physicians, Inc.

Madison Medical Group

Robert Atkins, M.D.

Ron D. Stollings, M.D.

John Mark Snyder, D.O.

705 Madison Ave.

Madison, West Virginia 25130

(304) 369-5170

9-10-96

Greg Hughes
Workers Comp. Division
4700 MacCorkle Ave. SE
Charleston WV 25304

RE: Christopher Lester
CP# 950006803.

Dear Mr. Hughes.

In answer to your previous letter concerning referral to the Pain Clinic, I have arranged an appointment at the Pain Clinic, CAMC General Division 501 Morris St. Charleston, WV. I am requesting authorization for Mr. Lester to be treated by the Pain Clinic.

Sincerely,

JM Snyder DO/PGB

500688.015.0582

MADISON MEDICAL GROUP RECORDS RELEASE AUTHORIZATION
705 MADISON AVE. MADISON WV 25130
PHONE (304) 369-5170 FAX (304) 369-1742

TO: Dr. Snyder
DOCTOR

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

April Lester

THE COMPLETE RECORDS IN YOUR POSSESSION CONCERNING MY
ILLNESSES AND/OR TREATMENTS DURING THE PERIOD FROM:

Copy Office records + MRS
NAME: Christopher Lester DATE: 8-14-96

ADDRESS: _____

BIRTHDATE: _____ SSN# _____

SIGNATURE: Christopher W. Lester
(IF RELATIVE STATE RELATION)

WITNESS: Paula Baldwin

THIS RELEASE AND AUTHORIZATION SHALL BE VALID FOR ONE YEAR
FROM ITS DATE OF SIGNATURE UNLESS TERMINATED IN WRITING BEFORE
THAT DATE.

RECORDS COPIED AND SENT:

Paula Baldwin
SIGNATURE
DATE 9-10-96

MADISON MEDICAL GROUP
AUTHORIZATION REQUEST FORM
FAX (304) 369-1742 PHONE (304) 369-5170

PATIENT NAME: Chris Lester ACCT #: _____

ID# & SS#: _____ DX: LBP

INSURANCE CARRIER: Workers Comp.

PHONE #: 369-1289 CONTACT NAME: _____

REQUEST FOR: _____

(PROCEDURE)

SCHEDULED WITH: Pain Clinic 348-6760

DATE/TIME: appt 9-12-

AUTHORIZATION NUMBER: _____

RECORDS:

☐ SENT BY MAIL

☐ FAXED

☐ GIVEN TO PATIENT TO HAND DELIVER

☐ PATIENT WAS NOTIFIED OF DATE, TIME, AND ANY SPECIAL INSTRUCTIONS.

REFERRING DOCTOR: 22-20-

DX codes 420- Comp H T11

auth/01-01-96/*8 * VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner



August 30, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21
HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from CLAIMANT dated 08/29/1996, is Approved.

THIS LETTER WILL SERVE AS AUTHORIZATION FOR CRA MANAGED CARE TO CONTINUE THEIR SERVICES THROUGH DECEMBER 31, 1996.

Your authorization number is 196242012.
Authorized Dates are 08/29/1996 through 12/31/1996.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Director, Legal Services Division
P. O. Box 3922
Charleston, WV 25339-3922

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SNYDER J MARK
LOGAN MEDICAL FOUNDATION/WORK REH

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

500688.015.0585

reor/01-01-96/*6 ** VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner



August 30, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21

Re: Claim 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

HEWETT, WV 25108-0000

PLEASE READ CAREFULLY - REOPENING DECISION

By letter dated , you were given notice that the above claim had been reviewed to consider reopening for payment of temporary total disability benefits.

The evidence provided is sufficient to reopen this claim.

THE EMPLOYER WAIVED THE TEN DAY NOTICE.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges	Director, Legal Services Division
P. O. Box 2233	P. O. Box 3922
Charleston, WV 25328-2233	Charleston, WV 25339-3922

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SNYDER J MARK
LOGAN MEDICAL FOUNDATION/WORK REH

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

500688.015.0586

auwh/01-01-96/*6 ** VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner



August 30, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21

HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [REDACTED]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - AUTHORIZATION WITHHELD

The request from J. MARK SNYDER, D.O., dated 08/28/96, for
REFERRAL TO A PAIN CLINIC is withheld pending THE NAME OF THE PAIN CLINIC THE
CLAIMANT IS BEING REFERRED..

Fax 926-5423

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SNYDER J MARK
LOGAN MEDICAL FOUNDATION/WORK REH

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

500688.015.0587

susr/01-01-96/*6 ** VENDOR COPY ** 1005904

Bureau of Employment Programs
Workers' Compensation Division
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304-1964

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner



August 26, 1996

SNYDER J MARK
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 21

HEWETT, WV 25108-0000

Re: Claim 950006803
S.S.N. [REDACTED]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - SUSPENSION DECISION

By letter dated 07/24/96, you were given 30 days to provide medical information to continue payment of your temporary total disability benefits. After again reviewing your claim, it appears there is insufficient information to pay additional temporary total disability benefits and your claim is now closed.

CONSIDERATION WILL BE GIVEN TO REOPENING THE CLAIM FOR TTD BENEFITS WITH THE CLAIMANT'S PETITION AND MEDICAL INFORMATION FROM THE CLAIMANT'S TREATING PHYSICIAN EXPLAINING THE AGGRAVATION OF THE CLAIMANT'S CONDITION AND THE FUTURE TREATMENT PLAN IN DETAIL.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges	Director, Legal Services Division
P. O. Box 2233	P. O. Box 3922
Charleston, WV 25328-2233	Charleston, WV 25339-3922

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SNYDER J MARK
LOGAN MEDICAL FOUNDATION/WORK REH

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

500688.015.0588

JAN. -10' 00 (MON) 16:58

P. 006

Charleston Area
Medical Center
Charleston, West Virginia



USE SPACE BELOW FOR IDENTIFICATION IF NECESSARY

NAME

ROOM NO.

REPORT OF CONSULTATION

C. Christopher

LESTER, CHRISTOPH W MR: 0000301457
PARSONS, MOLAN C. PNC: 1203282924
ADM 01/07/00 MDTV DOB 01/07/1971



From: Attending Physician

To: Consulting Physician

Date Requested

Borne Men

MDTV - Present

7 Jan 00

Report requested regarding:

Consultation Only ☐
Consult & Write Orders ☐
Accept For Transfer ☐

Findings:

29 x.v - w79

Feet - 7 yrs - Sales - hyperkalemia
fessuring

Sider of bones - hyperkalemia

Diagnosis:

10/21/00 ~~Diagnosis~~: Atopic Dermatitis - feet

Recommendations:

Dys - 0 Linc Out 0.7hs -

2 weeks -

0 LAC-HYDROIN Lot 127

BID

Date of Consultation:

7 Jan 00

Signature of Consultant

Molans Ours MD

17-6612 ITEM 1248

REPORT OF CONSULTATION

MR Rev. 11-98

500688.015.0590

MADISON MEDICAL, P.L.L.C
705 MADISON AVE.
MADISON, WV 25130
(304)369-5170 FAX#(304)369-1742

12/23/71
PATIENT NAME: Christopher Lester ACCT# 49864
DX: Chronic dermatitis-soles of feet
INSURANCE: BC/BS PEIA
AUTHORIZATION#: no precent needed per Stacy
REFERRING DOCTOR: 3
PHONE#: 369-6657 CONTACT NAME: _____
REQUEST FOR: MDTV

SCHEDULED WITH: Parsons
DATE/TIME: Jan. 7, 2000 2:15pm

RECORDS:

_____☐ SENT BY MAIL
_____☐ FAXED
_____☐ GIVEN TO PT TO HAND DELIVER

☒ PT WAS NOTIFIED OF DATE, TIME AND ANY SPECIAL INSTRUCTIONS.

[illegible]

500688.015.0592

DONE MEMORIAL HOSPITAL MADISON 25130

EMERGENCY DEPARTMENT
Nursing Progress Notes #1

CHART COPY

MD TIME OF ORDERS	MEDS	PHYSICIANS ORDERS	SITE	TIME DONE	INITIALS	LAB	EKG
						<input type="checkbox"/> CBC	<input type="checkbox"/> DRUG SCREEN
						<input type="checkbox"/> U/A	<input type="checkbox"/> ETOH
						<input type="checkbox"/> CHEM 8	<input type="checkbox"/> STREP SCREEN
						<input type="checkbox"/> CREATININE	<input type="checkbox"/> GC CULTURE
						<input type="checkbox"/> URIC ACID	<input type="checkbox"/> CHLAMYDIA SCREE
						<input type="checkbox"/> CALCIUM	<input type="checkbox"/> KOH SMEAR
						<input type="checkbox"/> T. BIL	<input type="checkbox"/> NaCl SMEAR
						<input type="checkbox"/> T. PROTEIN	<input type="checkbox"/> SPUTUM CULTURE
						<input type="checkbox"/> ALBUMIN	<input type="checkbox"/> HEMOCULT
						<input type="checkbox"/> ALT	<input type="checkbox"/> AMYLASE
						<input type="checkbox"/> AST	<input type="checkbox"/> BLOOD C/SX
						<input type="checkbox"/> LDH	<input type="checkbox"/> PT
						<input type="checkbox"/> CK	<input type="checkbox"/> PTT
						<input type="checkbox"/> PHOS	
						<input type="checkbox"/> TGL	
						<input type="checkbox"/> CHOL	
						<input type="checkbox"/> ALK PHOS	
						<input type="checkbox"/> CKMB	
						<input type="checkbox"/> THEO	
						<input type="checkbox"/> DILANTIN	
						<input type="checkbox"/> PHENOBARB	
						<input type="checkbox"/> DIGOXIN	
						<input type="checkbox"/> ACETAMIN	
						TIME/INITIALS:	
						X-RAY / OTHER DIAGNOSTICS	
						<input type="checkbox"/> CHEST	
						<input type="checkbox"/> FLAT & UPRIGHT ABDOMEN	
						<input type="checkbox"/> SKULL	
						<input type="checkbox"/> LUMBAR SPINE	
						<input type="checkbox"/> CERVICAL SPINE	

TIME	TREATMENTS & PROCEDURES	SIGNATURE	RESPONSE
9:00	130182 - 80-18 - out ambulatory 3 incident		
	Attorney		

MONITOR STRIP INTERPRET:

X-RAY INTERPRET

EKG INTERPRET

LAB RESULTS	CHEM 8	CK	CKMB	LDH	WBC	ABG	pH	pCO ₂
OTHER				URINALYSIS:	RBC			
				SG	BACTERIA			
				CHEM	NITRITE			

Discharge Instructions:	After discharge care sheet:
Rest, elevation warm compresses 14 COW	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Time Out 9:13
This time in 2-3 days	<input checked="" type="checkbox"/> Unremarkable <input type="checkbox"/> Unimproved
Return if worse	<input type="checkbox"/> Expired
	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair
	<input type="checkbox"/> Good <input type="checkbox"/> Poor
	<input type="checkbox"/> Admitted <input type="checkbox"/> Transferred
	<input type="checkbox"/> Home <input type="checkbox"/> Other

REFERRED TO DR	NURSE SIGNATURE	DIAGNOSTIC IMPRESSION
Dr. [Signature]	[Signature]	Acute Contusion, (R) foot
DISCHARGE INSTRUCTIONS	DOCTOR SIGNATURE	Dr. [Signature]

PATIENT NAME	DATE OF BIRTH	SEX	RACE	MARITAL STATUS	RELATIONSHIP
LESTER CHRISTOPHER WAYNE	07/01/71	MALE	WHITE	MARRIED	LESTER CHARLES (DAD)
MAILING ADDRESS	COUNTY OF RESIDENCE	HOME PHONE	EMERGENCY CONTACT'S ADDRESS	STATE	ZIP
PO BOX 1113	BOONE	304-369-6657	EMERGENCY CONTACT'S ADDRESS	STATE	ZIP
HOME ADDRESS	CITY	STATE	ZIP	PHONE	
BRANVILLE	WV	25053	EMERGENCY	TRI STATE HOMES	

500688.015.0593

MADISON MEDICAL, P.L.L.C.
705 MADISON AVE.
MADISON, WV 25130
PHONE# (304)369-5170 FAX# (304)369-1742

MEDICAL RECORDS RELEASE AUTHORIZATION

TO: Mark Snyder, DO
DOCTOR

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

patient

THE COMPLETE RECORDS IN YOUR POSSESSION CONCERNING MY
ILLNESSES AND/OR TREATMENTS DURING THE PERIOD FROM:

W. Comp records to med, etc.

NAME: Christopher Lester DATE: 3-31-99

ADDRESS: P.O. Box 1113
Danville, WV 25053

BIRTHDATE: [REDACTED] 71 SSN# [REDACTED] 2240

SIGNATURE: [Signature]
(IF RELATIVE STATE RELATION)

WITNESS: Maui L. Clark

THIS RELEASE AND AUTHORIZATION SHALL BE VALID FOR ONE YEAR
FROM ITS DATE OF SIGNATURE UNLESS TERMINATED IN WRITING BEFORE
THAT DATE.

RECORDS COPIED AND SENT BY: Kim Hayes

DATE: 4-9-99

[Signature] Usual charge

Patient Information

GROUP IMMUNIZATION INFLUENZA (FLU) VACCINE

Flu

Influenza (flu) is a respiratory disease caused by influenza virus infection. The types or strains of influenza virus causing illness may change from year to year, or even within the same year. People who get flu may have fever, chills, headache, dry cough and muscle aches, and may be sick for several days to a week or more. Most people recover completely. However, for some people, flu may be especially severe, and pneumonia or other complications including death, may develop.

Flu Vaccine

The regular flu vaccine contains killed influenza virus of the types selected by the U.S. Public Health Service and the Center for Biologics Evaluation & Research of the U.S. Food and Drug Administration. The types or strains of virus included are those which have most recently been causing influenza. The vaccine will not give you flu because it is a killed virus vaccine. As with any vaccine, flu vaccine may not protect 100% of all susceptible individuals.

Risks & Possible Side Effects

Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm at the injection site, or possibly fever, chills, headache or muscle aches. These effects usually last 24 to 48 hours. Most people who receive the vaccine either have no or only mild reactions. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur. Moreover, untoward medical events completely unrelated to vaccine administration may occur coincidentally in the aftermath period following vaccination.

Unlike the 1976 swine influenza vaccine, flu vaccines used subsequently have not been clearly associated with an increased frequency of Guillain-Barré Syndrome, which is associated with paralysis.

Special Notice - Vaccination is generally not recommended for the following people:

1. People allergic to eggs, or egg products
2. People sensitive to thimerosal;
3. People who have an active neurologic disorder;
4. People with a fever, acute respiratory or other active infections or illnesses.
5. Pregnant women;

If you have any of the above, please notify the staff. If you have any questions, please ask now or check with a physician or your health department before receiving the vaccine.

If you experience any significant reactions, see your physician.

I have read the above information about influenza and influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to ☐ me or ☐ the person named below for whom I am authorized to sign.

Information - Person to Receive Vaccine			
Chris Lester		1/21	25
Name (Please Print)		Birthdate	Age
P.O. Box 1113		Danville	WV 25053
Address Street		City	State Zip
Chris Lester			
Signature (Person receiving vaccine or Parent or Guardian)			

For Clinic Use
CarePoint
Name of Clinic
Date of Vaccination
Manufacturer and Lot No.
Pasteur Merieux Connaught Exp. 6-30-98
Site of Injection
R or L Deltoid IM .5cc
Chronic Disease
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

Note to Clinic: This portion of the form should be retained in your records for at least one year.

rbbe/09-27-96/*8

** VENDOR COPY **

1005904

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner



West Virginia Bureau of Employment Programs

- Job Service/Job Training Programs • Labor Market Information
 - Unemployment Compensation • Workers' Compensation
- an equal opportunity/affirmative action employer*

October 2, 1997

SNYDER J MARK DO
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 1113
DANVILLE, WV 25053-0000

Re: Claim 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - REHABILITATION BENEFITS

You have been approved for rehabilitation benefits on a TEMPORARY TOTAL disability basis from 10/01/97 through 11/14/97 because you are participating in job placement

THIS PROGRAM EXTENSION IS TO COMPLETE THE JOB PLACEMENT ACTIVITIES AND EXPLORE VOCATIONAL TRAINING OPTIONS.

These benefits will be stopped if you do not fully participate in the approved program.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Supervisor, Claims Defense Litigation
P. O. Box 4317
Charleston, WV 25364-4317

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
SPORTS MEDICINE CENTER
CRA
NELSON TIMOTHY W

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

RECEIVED OCT 06 1997

Workers' Compensation Division - Office of Claims Management

304-926-5264 FAX 304-926-5265 <http://www.state.wv.us/bep>

500688.015.0596

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** .ENDOR COPY **

1005904

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner



West Virginia Bureau of Employment Programs

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September 8, 1997

SNYDER J MARK DO
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 1113
DANVILLE, WV 25053-0000

Re: Claim 950006803
S.S.N. [REDACTED]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - REHABILITATION BENEFITS

You have been approved for rehabilitation benefits on a TEMPORARY TOTAL disability basis from 08/30/97 through 09/29/97 because you are participating in job placement

TTD BENEFITS ARE BEING EXTENDED WHILE THE CLAIMANT PARTICIPATES IN THE JOB CLUB WITH CRA MANAGED CARE.

These benefits will be stopped if you do not fully participate in the approved program.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Supervisor, Claims Defense Litigation
P. O. Box 4317
Charleston, WV 25364-4317

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If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
SPORTS MEDICINE CENTER
CRA
NELSON TIMOTHY W

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

RECEIVED SEP 09 1997

Workers' Compensation Division - Office of Claims Management

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Cecil H. Underwood
Governor

William F. Vieweg
Commissioner



West Virginia Bureau of Employment Programs

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- an equal opportunity/affirmative action employer*

September 8, 1997

SNYDER J MARK DO
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 1113
DANVILLE, WV 25053-0000

Re: Claim 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from CRA dated 09/05/1997, is Approved.

PER THE RECOMMENDATION FROM TODD GODDARD, THIS LETTER WILL SERVE AS AUTHORIZATION FOR A THIRTY DAY EXTENSION ON THE JOB CLUB SERVICES PROVIDED BY CRA MANAGED CARE, INC.

Authorized Dates are 08/30/1997 through 09/30/1997.

Your authorization number is 197248025.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Supervisor, Claims Defense Litigation
P. O. Box 4317
Charleston, WV 25364-4317

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SPORTS MEDICINE CENTER
CRA
NELSON TIMOTHY W

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

RECEIVED SEP 09 1997

Workers' Compensation Division - Office of Claims Management

500688.015.0598

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1005904

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner



West Virginia Bureau of Employment Programs

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• Unemployment Compensation • Workers' Compensation
an equal opportunity/affirmative action employer

August 14, 1997

SNYDER J MARK DO
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 1113
DANVILLE, WV 25053-0000

Re: Claim 950006803
S.S.N. [REDACTED]-3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from CRA dated 08/13/1997, is Approved.

PER THE RECOMMENDATION FROM TODD GODDARD WITH CRA MANAGED CARE, THIS LETTER WILL SERVE AS AUTHORIZATION TO REFER THE CLAIMANT TO SPORTS MEDICINE CENTER FOR A FUNCTIONAL CAPACITY EVALUATION.

Authorized Dates are 08/13/1997 through 11/13/1997.

Your authorization number is 197225099.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Supervisor, Claims Defense Litigation
P. O. Box 4317
Charleston, WV 25364-4317

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
SPORTS MEDICINE CENTER
CRA
NELSON TIMOTHY W

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

RECEIVED AUG 15 1997

Workers' Compensation Division - Office of Claims Management

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Cecil H. Underwood
Governor

William F. Vieweg
Commissioner



West Virginia Bureau of Employment Programs

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- an equal opportunity/affirmative action employer*

August 7, 1997

SNYDER J MARK DO
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 1113
DANVILLE, WV 25053-0000

Re: Claim 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - AUTHORIZATION DECISION

The request from CRA dated 08/05/1997, is Approved.

PER THE RECOMMENDATION FROM D. C. STEPHENS, CASE MANAGER WITH CRA MANAGED CARE, THIS LETTER WILL SERVE AS AUTHORIZATION TO PROVIDE JOB PLACEMENT ASSISTANCE THROUGH THE JOB CLUB PROGRAM.

Authorized Dates are 07/25/1997 through 10/25/1997.

Your authorization number is 197217080.

For procedures, such as surgery, that are authorized and require multiple providers, the attending physician should share the authorization number with those providers to assure payment of their bills.

If it is later determined you are not entitled to authorized services, payment will be recovered.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Supervisor, Claims Defense Litigation
P. O. Box 4317
Charleston, WV 25364-4317

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact the Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
CRA
NELSON TIMOTHY W

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

RECEIVED AUG 08 1997

RECEIVED AUG 08 1997

Workers' Compensation Division - Office of Claims Management

500688.015.0600

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1005904

Cecil H. Underwood
Governor

William F. Vieweg
Commissioner



West Virginia Bureau of Employment Programs

- Job Service/Job Training Programs • Labor Market Information
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August 11, 1997

RECEIVED AUG 12 1997

SNYDER J MARK DO
MADISON MEDICAL GROUP
705 MADISON AVENUE
MADISON, WV 25130

CHRISTOPHER W LESTER
PO BOX 1113
DANVILLE, WV 25053-0000

Re: Claim 950006803
S.S.N. [REDACTED] 3340
D.O.I. 08/10/1994

PLEASE READ CAREFULLY - REHABILITATION BENEFITS

You have been approved for rehabilitation benefits on a TEMPORARY TOTAL disability basis from 08/04/97 through 08/29/97 because you are participating in job placement

THE CLAIMANT WILL RECEIVE TTD BENEFITS WHILE PARTICIPATING IN THE JOB CLUB AT CRA MANAGED CARE. CRA WILL ASSIST THE CLAIMANT WITH JOB SEARCH FOR A POSITION WITHIN HIS PHYSICAL CAPABILITIES.

These benefits will be stopped if you do not fully participate in the approved program.

Any party to this claim may protest this decision by sending a written protest to the Office of Judges, with copies to all other parties to the claim, within 30 days from the date you receive this letter. See addresses below:

Office of Judges
P. O. Box 2233
Charleston, WV 25328-2233

Supervisor, Claims Defense Litigation
P. O. Box 4317
Charleston, WV 25364-4317

After the protest is filed, all parties may agree to seek mediation services. If so, you may contact Mediation Unit at P.O. Box 2964, Charleston, WV 25330-2964.

If you have any questions or concerns, you may reach me at 304-926-5264.

CC: TRI-STATE HOME CENTER
CRA
NELSON TIMOTHY W

Workers' Compensation Division
BY: Greg Hughes
Claims Representative 3/Senior

Workers' Compensation Division - Office of Claims Management

500688.015.0601



June 27, 1997

Dr. John Snyder
705 Madison Avenue
Madison, WV 25130

RE: Chris Lester
Claim No: 95000683
SSN: [REDACTED] 3340

Dear Dr. Snyder:

Mr. Lester has voiced a strong interest in vocational training as a Truck Driver. With the next training period beginning July 7, 1997 and ending August 7, 1997, it is my intent to obtain medical information/clearance for Mr. Lester's attendance. I have enclosed two Job Analysis for Truck Driving occupations. From these examples, would Mr. Lester physically be able to perform these jobs? () Yes. () No.

All applicants must be able to pass a D.O.T. physical prior to enrollment. It is Mr. Lester's belief that he is able to obtain this license.

Dr. Snyder, please list any objections that you have with Mr. Lester pursuing vocational training:

I doubt that Mr. Lester could
concentrate, stop material down, unload
the truck & carry materials

John M. Snyder D.O.
Signature

7-7-97
Date



COMPREHENSIVE REHABILITATION ASSOCIATES, INC.

JOB ANALYSIS

3 TITLE: Delivery Driver
 J.O.T. TITLE: Truck Driver
 J.O.T. CODE: 906.683-022
 HOURS WORKED: 8 hours per day

INDUSTRY: [REDACTED]EMPLOYER: [REDACTED]CITY/STATE: [REDACTED]PHONE: [REDACTED]TRAINING/EXPERIENCE REQUIRED: None

TASKS PERFORMED: Pull material, drive fork lift and load material onto truck. Strap material down. Drive truck to deliver material (up to two tons). Unload truck by hand. Carry product material to customers site. Maintenance (ie. sweeping).

MACHINES/TOOLS USED: Fork lift, truck, broom, buggy, sweeper.ENVIRONMENT: 80% outside, wet/humid and noisy.

SITTING: Hours/Day - <u>25%</u>	On - <u>truck seat/chair</u>
STANDING: Hours/Day - <u>5%</u>	Surface(s) - <u>concrete</u>
WALKING: Hours/Day - <u>70%</u>	Distance(s) - <u>up to 50 feet at a time</u>
KNEELING: Hours/Day - <u>None</u>	Surface - <u></u>
CRAWLING: Hours/Day - <u>None</u>	Distance - <u></u>

LIFTING: Occasional: <u>21-100lbs.</u>	Frequent: <u>11-20 lbs.</u>	Constant: <u>1-10 lbs.</u>	PUSHING: Occasional: <u>up to 100 lbs.</u>	Frequent: <u>-</u>	Constant: <u>-</u>
Weights			Weights		
From (Level) <u>Ground</u>	<u>Ground</u>	<u>Ground</u>	Distance <u>2 feet</u>	<u>-</u>	<u>-</u>
To (Level) <u>Shoulder</u>	<u>Shoulder</u>	<u>Shoulder</u>			

CARRYING: Occasional: <u>21-100 lbs.</u>	Frequent: <u>11-20 lbs.</u>	Constant: <u>1-10 lbs.</u>	PULLING: Occasional: <u>100 pounds</u>	Frequent: <u>-</u>	Constant: <u>-</u>
Weights			Weights		
Distance <u>50 feet</u>	<u>50 feet</u>	<u>50 feet</u>	Distance <u>50 feet</u>	<u>-</u>	<u>-</u>

CLIMBING: Frequency - <u>Occasionally</u>	On - <u>Steps</u>	Height - <u>15 feet</u>
BALANCING: Frequency - <u>Occasionally</u>	On - <u>Steps</u>	Height - <u>15 feet</u>
STOOPING: Frequency - <u>Frequently</u>	Related Task - <u>Pick up materials</u>	
CROUCHING: Frequency - <u>Occasionally</u>	Related Task - <u>Pick up materials</u>	
TWISTING: Frequency - <u>Constantly</u>	Body Part - <u>Neck, back, legs</u>	

REACHING
 Torso Level: Frequency - Frequently Related Task - Placing material onto buggy.
 Below Waist: Frequency - Frequently Related Task - Retrieving materials from ground level.
 Over Head: Frequency - Occasionally Related Task - Retrieve materials from shelves.
 HANDLING: Frequency - Constantly Related Task - Moving material from stock area to truck to consumer.
 FINGERING: Frequency - Occasionally Related Task - Sorting small bolts, nuts, nails.

FOOT MOVEMENTS

Right: Frequency - <u>Frequently</u>	Related Task - <u>Depress gas/brake pedal</u>
Left: Frequency - <u>Frequently</u>	Related Task - <u>Depress clutch</u>

ANALYZED BY: [REDACTED]
 DATE: [REDACTED]

RESOURCE PERSON(S) AND TITLE(S): [REDACTED]

☐ Approved ☐ Not Approved

Signature: [REDACTED]Date: / /Comments:

500688.015.0603



COMPREHENSIVE REHABILITATION ASSOCIATES, INC.

JOB ANALYSIS

TITLE: Truck Driver INDUSTRY: [REDACTED]
 D.O.T. TITLE: Truck Driver, Heavy EMPLOYER: [REDACTED]
 D.O.T. CODE: 905.663-014 CITY/STATE: [REDACTED]
 HOURS WORKED: 10 to 12 hours (4:00 a.m. to 2:00-4:00 p.m.) PHONE: [REDACTED]
 TRAINING/EXPERIENCE REQUIRED: High School Graduate plus CDL
 TASKS PERFORMED: Drive semi-truck, unload truck, check invoices for corrections or return and simple maintenance of truck.

MACHINES/TOOLS USED: Dolly, hand tools, truck

ENVIRONMENT: Indoors/outdoors, exposed to cold/hot weather, fumes, odors and around moving vehicles

SITTING: Hours/Day - <u>1-6</u>	On - <u>Truck seat</u>
STANDING: Hours/Day - <u>1-6</u>	Surface(s) - <u>Concrete, dirt, black top</u>
WALKING: Hours/Day - <u>1-6</u>	Distance(s) - <u>Up to 100 feet</u>
KNEELING: Hours/Day - <u>2-5</u>	Surface - <u>Metal</u>
CRAWLING: Hours/Day - <u>0-1</u>	Distance - <u>Boxes/metal</u>
LIFTING: Occasional Frequent Constant	PUSHING: Occasional Frequent Constant
Weights <u>100 lbs</u> <u>1-50 lbs</u>	Weights <u>50 lbs</u> <u>up to 50 lbs</u>
From (Level) <u>ground</u> <u>ground</u>	Distance <u>2 feet</u> <u>up to 100 ft</u>
To (Level) <u>waist</u> <u>waist</u>	

CARRYING: Occasional Frequent Constant	PULLING: Occasional Frequent Constant
Weights <u>100 lbs</u> <u>1-50 lbs</u>	Weights <u>50 lbs</u> <u>1-5 lbs</u>
Distance <u>90 feet</u> <u>90 feet</u>	Distance <u>1 foot</u> <u>6"</u>

CLIMBING: Frequency - <u>Frequently</u>	On - <u>truck/trailor</u>	Height - <u>4 1/2'</u>
BALANCING: Frequency - <u>Frequently</u>	On - <u>truck/trailor</u>	Height - <u>4 1/2'</u>
STOOPING: Frequency - <u>Occasionally</u>	Related Task - <u>unloading boxes</u>	
CROUCHING: Frequency - <u>Frequently</u>	Related Task - <u>unloading boxes</u>	
TWISTING: Frequency - <u>Frequently</u>	Body Part - <u>neck/back/legs</u>	

REACHING	
Torso Level: Frequency - <u>Frequently</u>	Related Task - <u>driving/unloading</u>
Below Waist: Frequency - <u>Frequently</u>	Related Task - <u>unloading</u>
Over Head: Frequency - <u>Frequently</u>	Related Task - <u>unloading</u>
HANDLING: Frequency - <u>Constant</u>	Related Task - <u>unloading/driving</u>
FINGERING: Frequency - <u>Occasionally</u>	Related Task - <u>pushing buttons on truck</u>
FOOT MOVEMENTS	
Right: Frequency - <u>Frequently</u>	Related Task - <u>gas/brake</u>
Left: Frequency - <u>Frequently</u>	Related Task - <u>clutch</u>

ANALYZED BY: [REDACTED] RESOURCE PERSON(S) AND TITLE(S): [REDACTED]
 DATE: [REDACTED]

Approved ☐ Not Approved ☐

Patient: [REDACTED]

Signature: [REDACTED] Date: / /

Comments: [REDACTED]